

Missouri

Data revised by State after July 2003

Mental Health and Substance Abuse Services in Medicaid and SCHIP in Missouri

Missouri Department of Social Services monthly Management Report states that as of July 31, 2003, 956,228 people were covered under Missouri's Medicaid/SCHIP programs. 871,283 of these were financed by Medicaid funding and 84,945 by SCHIP funding. In state fiscal year 2002, Missouri spent about \$4 billion to provide Medicaid services.

In 1998, Missouri obtained a Medicaid/SCHIP 1115 waiver from the federal government to expand eligibility using a combination of Medicaid and SCHIP funding. Specifically, Missouri:

- Uses Medicaid funding to cover:
 - children under 1 from families with incomes of 185% FPL or less, children from age 1-6 from families with incomes of 133% FPL or less, and children age 6-18 from families with incomes less than 100% FPL;
 - Uninsured parents who are in their second year of transitioning from welfare to work with income below 100% FPL and have a Medicaid/MC+ eligible child in the home;
 - uninsured women losing their Medicaid eligibility for 60 days post-partum, regardless of income, for 1 year plus 60 days (This group is covered for women's health services only).
- Uses SCHIP funding to cover children under age 19 from families with incomes up to 300% FPL who would not otherwise be eligible for Medicaid. Children with family incomes 186-225% of FPL are subject to co-payment. Children with family incomes from 226% - 300% FPL are subject to co-payments and monthly premiums equal to the average co-payment of the Missouri Consolidated Health Care Plan. This premium currently ranges between \$59.00 and \$225.00 per month.

Missouri Medicaid requires most families and children to enroll in comprehensive MCOs that deliver most mental health and substance abuse services. Those beneficiaries who belong to the aged, blind, and disabled eligibility groups are served through fee-for-service, as are those families and children who live in some rural areas of the State where managed care does not operate. As of July 2003 there were 936,228 Medicaid beneficiaries in the Medicaid program; 435,642 of these were enrolled in comprehensive Managed Care Organizations.

Medicaid

Who is Eligible for Medicaid?

Families and Children

1. Parents from families with incomes of 77% FPL or less.¹
2. Pregnant women and children under age 1 from families with incomes of 185% FPL or less
3. Children from age 1 to 6 from families with incomes of 133% FPL or less
4. Children age 6 to 19 from families with incomes less than 100% FPL.
5. Uninsured parents who are in the second year of transitioning from welfare to work with income below 100% FPL and have a Medicaid/MC+ eligible child in the home
6. Uninsured women losing their Medicaid eligibility for 60 days post-partum, regardless of income, for a maximum of 1 year plus 60 days. (This group is covered for women's health services only.)
7. Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act

¹ As of July 1, 2004, Missouri Medicaid reduced the income limit for parents to 75% FPL.

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Aged, Blind, and Disabled

1. Individuals who are age 65 or older OR meet the SSI definition of disabled or the state definition of blindness or receive SSI or Social Security based on age or disability. As of July 2003,
 - A. The income limit for aged, blind, and disabled beneficiaries was \$599/month for individuals and \$829/month for couples.
 - B. The resource limits for this group was \$999.99 for individuals and \$2000 for couples.
 - C.
2. All who meet the State's definition of blindness and receive no more than \$470/month/individual and \$940/month/couple in State supplementary payments and federal SSI payments combined.
3. All who meet the SSI definition of disability or are over 65, live in a group setting, and receive no more than \$390/month in State supplementary payments and federal SSI payments combined.
4. All working individuals between the ages of 16 and 64 who meet the SSI definition of disability and have an income of 250% FPL or less. Those with incomes of 150% FPL or more must pay a premium that varies by income in order to participate in the Medicaid program.
5. Individuals under the age of 21 who are receiving active treatment as inpatients in psychiatric facilities or programs, reside in a nursing facility, or reside in an ICF-MR.
6. Individuals over 65 or under 18 years of age who are eligible for in institutions and who have income no more than \$965/month.

Medically Needy

Missouri does not have a medically needy program.

Waiver Populations

Missouri has an 1115 waiver that allows the State to cover low-income families as previously described.

What Mental Health/Substance Abuse Services are Covered by Medicaid?

Medicaid must cover some types of services (mandatory services) and may cover some other types of services (optional services). The information presented here identifies the types of service Missouri Medicaid covers and the coverage requirements for those services. These services are presented grouped as they are in the Medicaid State plan that Missouri must maintain under Medicaid law. Only those types of services that include mental health or substance abuse services are discussed. (NOTE: Benefits are limited for parents who are in the 2nd year of transition from welfare to work.)

Mandatory State Plan Services

Inpatient Hospital Services		
Service	Description	Coverage Requirements
Inpatient Mental Health and Substance Abuse Services	<ul style="list-style-type: none">• Psychiatric services provided in the specialized wing of an acute care hospital; or an Inpatient Psychiatric Facility (to those under 21 years of age)• Detox in acute hospitals	<ul style="list-style-type: none">• Inpatient psychiatric hospital services are not covered for beneficiaries between the ages of 22 and 65. (Please see the table, "Inpatient Psychiatric Services (for persons under the age of 21)," for more information.)

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Outpatient Hospital Including Rural Health Center and Federally Qualified Health Center Services		
Service	Description	Coverage Requirements
Outpatient Psychiatric and Substance Abuse Care	Substance abuse and mental health services that would be covered if provided in another setting may be provided by an outpatient hospital clinic. Except, day treatment services may not be billed as outpatient hospital services.	<ul style="list-style-type: none"> Services must be physician or psychologist directed Services must be performed within the licensed outpatient facility Mental health and substance abuse services provided in an outpatient hospital must meet the same requirements as those provided in another setting information) Specific opioid treatments, such as methadone and/or LAAM are not covered
Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)	FQHCs and RHCs may provide the same mental health and substance abuse services as any other provider-as long as the personnel providing the service meet the same qualifications as other providers.	<ul style="list-style-type: none"> Services must be physician or psychologist directed Services provided by an FQHC or RHC must meet the same requirements as services provided by another provider.

Physician Services		
Service	Description	Coverage Requirements
Physician Services	<p>Physicians may provide substance abuse and psychotherapy services as described under "Rehabilitative Services".</p> <p>Licensed psychologist may provide psychotherapy services under the Physician's program.</p>	<ul style="list-style-type: none"> The service must be within the scope of the practice of medicine, as defined by state law. Physicians providing psychotherapy must have completed a residency in psychiatry; any Medicaid certified physician may provide substance abuse services. For psychologist the services must be within the scope of practice of psychotherapy, as defined by state law Services cover Medicaid eligible recipients 0-125 years of age. .

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)		
Service	Description	Coverage Requirements
Counseling/Social work services	<p>Services include the following:</p> <ul style="list-style-type: none"> assessment crisis intervention individual therapy family therapy group therapy 	<ul style="list-style-type: none"> Service must be needed to ameliorate or treat a condition identified in an EPSDT screen Services may be provided by a licensed social worker or licensed professional counselor Some services must be prior authorized by the Medicaid agency for children 0-2.

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Optional State Plan Services

Clinic Services		
Service	Description	Coverage Requirements
Community mental health center services	<ul style="list-style-type: none"> Services to maintain seriously mentally ill beneficiaries within the community at a level of care less restrictive than an inpatient psychiatric hospital or nursing facility. Services may include: <ul style="list-style-type: none"> Intake/annual evaluation, psychosocial rehabilitation, crisis intervention, community support, intensive community support, medication administration and medication services 	<ul style="list-style-type: none"> To qualify for services, beneficiaries must, as identified through a medical evaluation and assessment process, be found to be seriously and persistently mentally ill To continue receiving services <ul style="list-style-type: none"> a medical/clinical review team must periodically review the situation and approve continuation, and a physician must review and re-certify the beneficiary's treatment plan.

Inpatient Psychiatric Services (for persons under the age of 21)		
Service	Description	Coverage Requirements
Inpatient Psychiatric Services for persons under the age of 21		<ul style="list-style-type: none"> Services may only be provided within a: <ul style="list-style-type: none"> State-licensed psychiatric facility or program within a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations; Comprehensive Substance Treatment and Rehabilitation Services (CSTAR) program, or psychiatric facility operated by the Missouri Department of Mental Health To obtain inpatient psychiatric services a beneficiary must be medically certified as requiring that level of care Services must be prescribed by a physician The Medicaid agency's designated agent must authorize the admission and the length of stay.

Rehabilitative Services		
Service	Description	Coverage Requirements
Adult day health care program	<ul style="list-style-type: none"> An individual may receive up to 10 hours of care per day, including, <ul style="list-style-type: none"> a program of organized therapeutic, rehabilitative and social activities, medical supervision, medication services, meals and snacks, and necessary transportation. 	<ul style="list-style-type: none"> To receive care the beneficiary must be physically, mentally, socially, or emotionally impaired to a level of care that would otherwise require institutionalization and need daytime supervision and services to maintain or improve their level of functioning. Each beneficiary in treatment must have a plan of care that is developed by the provider within five days of the first contact and is revised at least every six months.

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Rehabilitative Services		
Service	Description	Coverage Requirements
Community psychiatric rehabilitation services	<ul style="list-style-type: none"> Services to maintain seriously mentally ill beneficiaries within the community at a level of care less restrictive than an inpatient psychiatric hospital or nursing facility. Services may include: <ul style="list-style-type: none"> Intake/annual evaluation, psychosocial rehabilitation, crisis intervention, community support, intensive community support, medication administration and medication services 	<ul style="list-style-type: none"> To qualify for services, beneficiaries must, as identified through a medical evaluation and assessment process, be found to be seriously and persistently mentally ill To continue receiving services <ul style="list-style-type: none"> a medical/clinical review team must periodically review the situation and approve continuation, and a physician must review and recertify the beneficiary's treatment plan. The CPR provider shall develop and maintain an Individualized Treatment Plan that sets forth the care, treatment and rehabilitation goals and objectives for individuals with mental illness and that details the treatment program as required by law, rules and funding sources.
Comprehensive community support services	<ul style="list-style-type: none"> Services include any medical or remedial service reasonable and necessary for maximum reduction of behavioral disability and restoration of the beneficiary to his or her best possible functional level. Services may include: <ul style="list-style-type: none"> intake, assessment, evaluation and treatment planning; community support , specialized sexual abuse treatment 24 hour crisis stabilization and intervention intensive in-home services medication management and monitoring; day treatment/ psychosocial rehabilitation therapeutic counseling or consultation services not covered separately supported independent living and transitional living 	To receive services a beneficiary must have an individualized treatment and rehabilitation plan that is periodically revised.

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Rehabilitative Services		
Service	Description	Coverage Requirements
Comprehensive day rehabilitation services	<ul style="list-style-type: none"> Intensive, comprehensive services to prevent and/or minimize chronic disabilities while restoring the individual to an optimal level of physical cognitive and behavioral functions. This is a post-acute program serving those who demonstrate the need for rehabilitation and specialized supportive care. Emphasis in this program is on functional living skills, adaptive strategies for cognitive, memory or perceptual deficits. 	<ul style="list-style-type: none"> To qualify for services a beneficiary must have a primary diagnosis of traumatically acquired brain damage resulting in residual deficits and disability Services may only be provided in a free-standing rehabilitation center or in an acute hospital setting with space dedicated to head injury rehabilitation.
Comprehensive substance treatment and rehabilitation services (CSTAR)	<p>Services may include:</p> <ul style="list-style-type: none"> day treatment, individual counseling, family therapy, group counseling, codependency counseling, group educational counseling, ADA community support services, intake/screening, and comprehensive assessment Specific opioid treatments, such as methadone and/or LAAM 	<ul style="list-style-type: none"> To qualify for services beneficiaries must have been assessed to a particular level of CSTAR treatment. Each beneficiary must have an individual treatment plan The individual treatment plan must be reviewed and signed by a licensed psychologist, board-certified psychiatrist, or licensed physician. Services must be approved by the Department of Mental Health.

Targeted Case Management		
Service	Description	Coverage Requirements
Targeted Case Management (TCM)	<ul style="list-style-type: none"> Services to assist eligible children and adults gain access to needed psychiatric, medical, social, educational, vocational, and other services necessary to maximize the recipient's adjustment and functioning within the family and community Services to coordinate the multiple service systems that typically impact recipients with SED and SMI. Specific services include <ul style="list-style-type: none"> assessment, planning for services case coordination case documentation 	<ul style="list-style-type: none"> Individuals receiving TCM services² must <ul style="list-style-type: none"> be 6 to 17 years of age, and <ul style="list-style-type: none"> have a DSM III-diagnosis, and be Severely Emotionally Disturbed (SED) by the State's definition, require case management services, and be participating in, being discharged from, or be on a waiting list for community based, residential, or a facility inpatient programs and services funded by the Department of Mental Health. Be at least 18 years of age, suffering from severe mental illness (SMI), and <ul style="list-style-type: none"> been discharged within the last thirty days from an Inpatient hospital for psychiatric treatment, or; have had at least two periods of

² Missouri provides Targeted Case Management Services to other groups, but these groups are not defined by the need for mental health or AODA services.

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Targeted Case Management		
Service	Description	Coverage Requirements
		<p>inpatient hospitalization for psychiatric treatment within the last twelve months, or</p> <ul style="list-style-type: none">▪ be participating in the DMH supported community living program, or▪ have been conditionally released from a psychiatric facility; or▪ meet the criteria for inpatient psychiatric hospitalization and will be diverted from inpatient hospitalization through use of community-based treatment.

SCHIP Medicaid Expansion Program

Who is Eligible for the SCHIP Medicaid Expansion Program?

As previously discussed, Missouri obtained a Medicaid/SCHIP 1115 waiver from the federal government to establish Missouri Care Plus. This program serves

1. Children under age 1 from families with incomes between 186 and 300% FPL;
2. Children from age 1 to 6 from families with incomes between 134 and 300% FPL.
3. Children from 6 to 19 from families with incomes between 101 and 300% FPL.

Families with eligible children and incomes above 225% FPL must pay monthly premiums for program participation that vary from \$59 to \$225 based on income and family size.

What Mental Health/Substance Abuse Services are Covered by the SCHIP Medicaid Expansion Program?

Service coverage in Missouri Care Plus is identical to coverage in the Medicaid program, which was described in the previous section.

Separate SCHIP Program

Missouri has no Separate SCHIP Program